THE PHYSICIANS HEALTH PLAN OF MINNESOTA

A Case Study of
Utilization Controls in an IPA

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Introduction

Experience suggests that the success or failure of an IPA-HMO will be directly related to the adequacy of its utilization and cost controls rather than to the plan's ability to enroll members -- the problem most often faced by other types of HMOs. At the same time, however, IPAs, perhaps even more so than other HMO prototypes, have been susceptible to financial difficulties. With all too few exceptions, they have not implemented the systems necessary to control utilization of medical services which are so essential to their viability.

The experience of the Physicians Health Plan (PHP) of Minnesota, a medical society sponsored IPA which began operations in September, 1975, is fairly typical of similar plans elsewhere in the country. PHP enrolled in its first 12 months over 14,000 people, with minimal marketing efforts. Enrollment penetrations in individual employer groups averaged 25% and higher; in a number of key accounts, PHP all but replaced the commercial insurance option.

In spite of this initial enrollment success, during its first full year of operation (1976), PHP lost over $550,000, primarily due to inpatient hospital costs exceeding what had been projected. PHP's premiums anticipated 575 bed days of hospital use per 1,000 enrollees during its first year; in the 10 months of 1976 during which there was significant enrollment (March - December), the Plan operated at 634/1,000 bed days. With the additional obligation of 75 "deferred" maternity days/1,000 enrollees, PHP operated at approximately 709 bed days during its first year. The hospital admission rate, projected at 115/1,000 members in 1976, was 110 (including only a few maternity cases).

Physician encounters and ancillary services, particularly outpatient lab and x-ray, exceeded what was projected as well, though the cost per unit of service was actually below what had been projected in the rates.

Why these seemingly dismal results in the face of what otherwise appeared to be a very successful plan? (PHP began operations with over 1,200 doctors, 22 hospitals and 300 pharmacies.) The problems can be traced primarily to the utilization/cost control systems implemented by PHP, a "system" which evolved through a number of distinct stages. This monograph will review this history, the utilization and cost controls implemented by the plan, and their relative impact. Hopefully these experiences will be educational for other plans faced with similar decisions and circumstances in the future.

History and Background

The Physicians Health Plan is a Minnesota, state-certified HMO which began serving members in August 1975. It was sponsored by the Hennepin County Medical Society, through which initial startup funds were obtained. (The balance of the Plan's initial capitalization and working capital requirements came from a loan secured through a local insurance carrier, an obligation which is currently being repaid.)

The impetus for development of PHP was competitive in its origin. Seven other HMOs currently operate in the same general market area; PHP was formed as an outlet through which non-clinic-based physicians could offer an alternative to the growing number of competing HMOs in the community.

The marketplace in which PHP operates is highly competitive. The eight competing HMOs collectively serve approximately 13.5% of an estimated population of 2.5 million people and over a third of the employed market. It is conservatively estimated that half the population of the area will be enrolled in some type of HMO by 1985.

Only one of the HMOs in PHP's service area is federally qualified, the balance having elected to seek state certification only. In the case of PHP, this decision not to seek federal qualification was motivated by both financial and marketing considerations. PHP is stable financially, having operated with surpluses in each of the past two years, so federal funding support has not been necessary. Similarly, employers in the area have been willing to offer the plan in the absence of being required by federal law

to do so. This has been true of most of the other state-qualified plans in the area as well.

The seven HMOs with which PHP competes include two staff model plans, two group practice models, one hospital-based plan, one network-primary care based plan and another IPA. All except PHP "community rate" their enrolled groups, while Physicians Health Plan utilizes a modified "experience-rating" concept. PHP premiums are based initially on an analysis of each group's age/sex characteristics, utilization history, and competitive considerations; renewal rates are based on an analysis of claim experience for the group's enrollees in PHP and the overall financial needs/experience of the plan.

Marketing

PHP is marketed through a field staff which includes a marketing director, an associate director and two marketing representatives. These personnel are supplemented by a three-person clerical staff, who handle a 12-county service area. PHP markets two basic benefit packages, the primary difference between the two being a $3 office visit copayment on one of the options. The "high option" benefit package includes the following features:

THE PHYSICIANS HEALTH PLAN BENEFITS:	MEMBER PAYS:
<u>Physician Services</u>	
"In Office" Services of Participating Physician	No Charge
Preventive Health Services	
Periodic health evaluations	
Well baby care	
Immunizations	
Medical Care and Treatment	
Office visits	
Medical care	
Consultants	
Minor surgery	
Diagnostic X-ray and lab	
Therapeutic X-ray	
Eye examinations	

"In Hospital" Services of Participating Physician	No Charge
Surgical service Surgical assistance Anesthesiology Other medical services	
Outpatient Services for Mental Health, Alcoholism and Chemical Dependency	
Up to 30 visits per year	$10 per visit

Hospital Services

Inpatient Services (Except for Mental Health, Alcoholism and Chemical Dependency)	
100% -- Unlimited days -- based upon common semiprivate room rate in a participating facility	No Charge
Medically necessary services and supplies	No Charge
Outpatient Services	$15 per visit
Medically necessary services and supplies at a participating facility	
Emergency Room Services	$15 per visit
Inpatient Services for Mental Health, Alcoholism and Chemical Dependency	
Semiprivate room and board for up to 73 days per calendar year	20% of eligible expenses
Services of a participating physician while a bed patient	No Charge

Maternity Services	
Services of participating physicians and hospitals including prenatal and postnatal care	No Charge
Outpatient Prescription Drugs	
Obtained at a participating pharmacy by prescription from a participating physician	$2.50 per prescription or authorized refill
Miscellaneous Services	20% of eligible expenses
Emergency ambulance expenses Accidental dental expenses Home Health Agency expenses Private duty nursing expenses Prosthetic and durable medical equipment expenses	
Out-of-Area -- Emergency Benefits	
Necessary services and supplies when the member is unable to reach a participating hospital or physician	20% of the first $2,500; t none thereafter up to $125,000 per person per calendar year

Premium rates for these benefits vary significantly from one group to another. The average single rate for 1980 renewals is approximately $39; for families, the average is $112.

Administration and Finance

PHP operates under a long-term management contract with Charter Med, Inc., a Minnesota firm which provides similar services to a number of other plans around the country. This particular agreement includes both the financial and administrative functions of the plan; claims and data processing are fully computerized, as are major components of PHP's financial reporting systems.

Internal staff serving a membership of approximately 55,000 enrollees is as follows:

Administration (claims and data processing)	13
Finance	2
Utilization Review	5
Marketing	7
Executive Staff/Other	4

Utilization/Cost Control Systems and Procedures

PHP's utilization/cost control system has evolved through a number of distinct stages, each of which has had a varying impact on the plan's doctors and financial condition.

- Stage 1: "This is the doctor's plan; it is not in their self-interest to abuse it; therefore, no mandatory system of utilization/cost controls need be enforced."

This was the attitude of PHP's sponsors at its inception, and for approximately the first six months of its operations. PHP began with no formal, established utilization review system -- there had been considerable thought and discussion on the subject, many good intentions, but no hard results. In part, this error occurred because of assurances made to physicians during development of the Plan that they could continue to practice medicine for their HMO patients as they had in the past. PHP's rates, however, assumed strong hospital admission controls and concurrent review. (Even with these assumptions, however, PHP's rates were projected initially at the top of the HMO competition in the area.)

Stage 1

Initial Elements of PHP's
Utilization Review/Control System

- no formalized internal controls
- faith in hospitals to control costs through cooperation with PSRO in-house reviewers
- physician fees tightly controlled
- frequency of office services not monitored

Physician fees during this initial phase of PHP's operations were as tightly controlled as hospital utilization was not, with maximums applicable to every procedure. The same fee maximums applied to every doctor in the plan, regardless of specialty, who performed a particular procedure. The intention was to upgrade fee allowances at least once a year based on inflation, but the financial position of the plan did not allow this for over two years.

It is easy to second guess these decisions since we now have the advantage of hindsight. IPAs were fairly new and experience limited when PHP began operations in 1975. The evidence that mandatory utilization and cost controls are so essential to the viability of this type of plan was not so overwhelming as it is today. From what experience existed, it was probably reasonable to conclude that "it won't happen to us."

Because enrollment was limited during PHP's first year, the financial impact of these shortcomings was not dramatic. The organization appeared

to be losing money, but the amounts were not significant and were dominated by losses in the administrative area because of a (predictable) low enrollment/high overhead problem.

- Stage 2: "There is no conclusive evidence that PHP doctors are or will abuse their plan."

The Board and various utilization review committees of PHP were skeptical that more than a few doctors were "abusing" the plan and requested hard data to prove that there was in fact a major problem. If participating PHP physicians were made aware of a problem, it was argued that they would surely regulate themselves more stringently. A physician newsletter was thus initiated to all plan doctors, urging them to be more prudent in their hospitalization of Plan members.

Utilization review committees were also established to deal with each of the then-defined problem areas: inpatient hospital, psychiatry/chemical dependency, outpatient hospital and office services. Cases of abuse were brought to the attention of the appropriate committee. Even when individual cases were found to be questionable, however, concrete action was rarely taken. PHP did not have disciplinary procedures in place to deal with "problem" physicians.

Stage 2

New Elements of Utilization/
Cost Control System

- utilization review committees appointed to review selected claims
- newsletter to doctors implemented to communicate problems and educate them on their responsibilities as HMO physicians

The primary reason that the efforts of PHP's various utilization review committees were ineffective during this period was that their efforts were misdirected. The cause of PHP's cost overruns in the hospital area was not a few doctors who were abusing the plan but a more pervasive problem: habits formed through years of insurance reimbursement which required hospitalization for an individual to be eligible for coverage, Friday admissions for Monday surgeries, six-day lengths of stays for normal OB deliveries, diagnostic admissions, extra days caused by cumbersome hospital regulations, etc.

In addition, there were still no "hard" data to prove conclusively that a serious problem existed. In May 1976, however, PHP received April incurred-hospital bills exceeding the reserves set aside for all such expenses incurred to that date. With the knowledge that the majority of April hospital expenses (and portions of prior months as well) were not reported at that time, it was then apparent that a major problem existed, though the magnitude was not known. It was apparent as well that many of PHP's hospitals were not seriously reviewing lengths of stay. March and April 1976 hospital days were 722/1,000 and 805/1,000, respectively, not much better than the local Blue Cross experience.

Mental health/chemical dependency inpatient days were 69/1,000 and 114 per 1,000 members during these two months. With this new information, PHP moved quickly into an expanded utilization/cost control program.

- Stage 3: "This is the doctor's plan, but they are killing it. We have to do something and voluntary controls are not working."

Part of the difficulty in finding a solution related to the size of PHP: no single physician treated enough Plan patients to be seriously affected if it lost money.[2] The doctor's maximum liability was 20% of the fees they charged for seeing HMO patients (subject to fee ceilings), a small price compared to the cost of losing patients to the other HMOs in the community. The average amount of reserve withheld from PHP doctors during all of 1976 was less than $180.00 per physician.

Compounding the problem were deficiencies in PHP's subscriber and group master agreements. For example, services were eligible for reimbursement so long as the care was "recommended or approved by a Plan physician" -- a typical HMO contract provision which works well in group or staff model plans but not in IPAs. When PHP doctors referred their patients to non-

Stage 3

New Elements of Control System

- hospital notification program (with no enforceable, communicated disciplinary procedures to deal with those who did not comply)
- a serious crackdown on out-of-plan referrals
- initial attempts to catalog chemical dependency and alcoholism residential treatment centers and encourage their use as an alternative to expensive hospital-based inpatient treatment
- distribution of patient identification stickers for medical records in physician offices

2. The issue of PHP's size, the number of participating doctors, hospitals and pharmacies, is a particularly crucial one. The selection of doctors available to plan members is the element which makes PHP so marketable. On the other hand, it is a disadvantage from a financial viewpoint -- it is certainly more difficult to control a plan with 1,400 physicians than one with 100. On balance, however, the size has been viewed as an asset rather than a liability.

participating providers, the Plan was obligated for the results. PHP had no disciplinary system in place to deal with those providers who did not follow established procedures and protocols and referred improperly. Where care was provided by non-participating providers, the Plan lost all control over fees and withheld no risk reserve from the participating doctor. Hospital confinements were almost without exception more costly, both in terms of length of stay and cost per day when Plan members were treated at non-participating facilities.

The solution to the referral problem was simply a recognition by PHP that it was a "closed panel" HMO and not "open panel." Like any HMO, members should only have been referred to non-participating providers when the services required were not available through a participating doctor, hospital or pharmacy. In an HMO having over 1,200 doctors under contract, this should rarely have occurred.

In May, 1976, implementation of pre-admission certification for all hospital confinements was urged. Even though PHP had been in operation for nine months, there had to that point been only two months of really bad financial experience. The losses to that stage were not substantial and had not significantly impaired the viability of the organization.

Though considerable discussion followed on the need to impose mandatory hospital controls, a voluntary "pre-admission notification system" for hospital admissions was installed. Participating doctors were required to notify the Plan before hospitalizing a PHP patient; information obtained by phone was to be relayed to at least one review physician, either someone on the same hospital staff or a physician from the utilization review committee in the same specialty. The admitting doctor was to be reminded that the patient was a PHP member and that the physician was ultimately responsible for the costs associated with the confinement (i.e., through forfeiture of reserves withheld at year end). Chart stickers were distributed to the offices of participating doctors to remind the physician of the need to call the Plan before hospitalizing a PHP member.

Though this system unquestionably saved the Plan some money, principally because a few physicians were influential enough with their peers to get results, less than 50% of the doctors complied with the system and those who did were generally not the source of the problem. In addition, the dollars saved under this pre-notification system were not sufficient to offset monthly operating losses, and utilization continued to exceed that allowed for in the Plan's rates (June 628.6, July 638.1, August 726.4). In the absence of disciplinary authority to deal with physicians who hospitalized patients without notifying the Plan, there was no means of enforcing compliance. The most common excuse from physicians who failed to comply with the system was that the "office staff" made hospital arrangements, that the doctors were "unaware" that particular patients were PHP members.

By the fall of 1976, PHP had sufficient data on the pattern of claim incurral to make reasonably accurate estimates of actual incurred liabilities for each month by the end of that same month. Adjustments to earlier financial statements reflected accumulated losses of nearly $275,000 for the year, with most of the problems evident in the area of hospital admissions, particularly alcoholism and chemical dependency cases. (Mental health and chemical dependency cases accounted for more than 10% of all admissions during the summer and fall of 1976.) The Board of PHP, which now had consumer representation, demanded that "something be done" to stem the losses before it was too late.

Encouraged by the earlier success in controlling out-of-plan referrals, the Board began to look twoard the consumer as the culprit and urged rate increases and controls.

- Stage 4: "We are selling a Cadillac at Ford prices."

Rates were increased drastically on group renewals (an average of 18-20%) on all new enrollments. Subscriber and master group contracts were amended to preclude use of non-participating providers without prior written authorization from management and to provide for mandatory Plan approval of all psychiatric and chemical dependency confinements in advance of hospitalization. Copayments were increased on all outpatient hospital services (from $5 to $15) and mental health visits (from $5 to $10 per visit); inpatient mental health care copayments were increased to 20%, creating a financial incentive for members to accept use of primary care treatment centers in lieu of more expensive hospital-based treatment programs. On the whole, participating physicians cooperated with these changes -- none dropped out as a result.

Stage 4

New Elements of Controls

- changes in subscriber and group contracts to tighten controls
- copayments added on office services ($3 per office encounter, $15 for eye exams)
- requirements added to member contracts for prior approval of all chemical dependency and alcoholism confinements (with a penalty of non-coverage for services)
- initial attempts to hire a medical director
- major rate increases imposed

The end of 1976 (after approximately 17 months of operations) brought financial news of still more concern. Hospital bed usage per member had averaged 634 for the year; worse still, maternity benefits, deferred for most of 1976, were beginning to have an impact. January 1977 hospital results were the worst ever, annualized at 950 bed days/1,000 members, with mental health and chemical dependency admissions contributing more than a third of this amount. Operating deficits and high rates had stopped marketing activity altogether. The attractive better risk employers in particular were turned off, and let PHP know that because of its inability to control costs, they would not offer the plan. Concern in both the employer and medical community began to mount regarding the viability of the Physicians Health Plan. Hospital <u>outpatient</u> costs were soaring as many group members continued using the hospital emergency room for primary care.

- Stage 5: "PHP is on a collision course with bankruptcy; if something drastic is not done immediately, it will be too late."

Despite the increased copayments and controls placed on the members, PHP physicians were finally beginning to realize that <u>their</u> actions were also contributing to the losses in their plan; that they would increasingly be left with poorer-risk groups; and that until they learned to control costs for existing enrollees, there would be no chance for improvement.

Subsequent to this realization, participating physician agreements were amended to allow for disciplining or terminating contracts with doctors at the discretion of the Board and (if required) to vary the reserve amount withheld from physician fees to fund any further operating deficits. Plan physicians were advised that the amount withheld from their fees as a "reserve" would be increased each quarter to cover <u>current</u> operating deficits. The logic was that this would make PHP doctors more aware on a <u>current</u> basis of the need to control costs and help stablize the plan's short-term financial position by assuring at least "breakeven."

First quarter 1977 operating results showed that to balance its books, PHP would have to withhold 40% of physician fees -- and this assumed no additional operating losses in subsequent periods. PHP was on the horns of a dilemma: if it paid its doctors only 60% of their fees, most would probably drop out; if it did not (or didn't find some alternative solution), it would still be out of business. Rates couldn't be raised any further; no more copayments were practical; marketing had been halted.

Stage 5

- variable withholding (from physician fees) accepted as an option by the Board of Directors
- participating physician agreements written to allow termination of doctors and variable withholding from their fees
- corporate bylaws amended to allow termination of doctors by a newly established credentials committee
- physician profiles analyzed, costly physicians identified and dealt with on a 1:1 basis
- appointment of part-time medical director
- change in contract language covering services provided in the hospital emergency room

Appointment of a part-time medical director to analyze individual hospital claims and physician profiles did not solve the problem either. With 1,200 participating doctors, little financial impact resulted from the efforts of this one person who had no personal stake in the financial success of the Plan and who reasonably tended to accept explanations of "mitigating circumstances" when questionable admissions/lengths of stay were discovered.

The losses continued to mount. Tentative results for March and April showed that the Plan operated at 685 and 743 hospital bed-days/1,000 members -- based on incomplete results which were certain to go higher.

One area where the action taken had some positive results was in the utilization of the hospital emergency room. Supplementing the higher copayments previously implemented, this particular benefit was modified to exclude services received during normal physician office hours which could have been provided routinely in the doctor's office (e.g., treatment of sore throats, colds, etc.).

- Stage 6: "We have three choices: go out of business; ask our physicians to work for nothing to maintain their Plan; or install mandatory hospital controls."

The Board elected to pursue the latter course. The physicians were so notified in a letter detailing the need for such a system and its content. Basic elements of this letter were the following:

a. implementation of a certified hospital admission program to encompass all non-emergency inpatient admissions. Prior approval of the Plan would be required before any PHP member could be hospitalized. The program would operate initially using screening criteria developed by the Foundation for Health Care Evaluation; it would be staffed by experienced RNs, with back-up from a panel of physician advisors. Non-compliance would in the first instance result in a warning; a second offense would result in a disallowance of all fees of the admitting physician; a third in termination from the plan.

b. concurrent review. In conjunction with this program, PHP staff personnel would monitor the length of stay and care of those Plan members who were hospitalized. This activity by Plan personnel would be supplemented through a review of these same cases by Plan physicians on the staffs of each participating hospital.

c. review of physician fees. Coincident with the installation of these controls on utilization of hospital services, a review would be undertaken of the fees and charge patterns of all participating doctors. A panel of physician advisors to the Plan would review the charges for services in the physician's office, the need for such a program being most apparent in the level of use/utilization of laboratory and x-ray services.

Stage 6

New Elements of Control System

- prior approval by management for all hospital confinements
- concurrent review of all hospital lengths of stay
- hiring of a fulltime medical services director
- variable reserve withholding implemented
- implementation of a newsletter to members to educate them regarding their impact on health dollars

Less than a dozen PHP doctors dropped out of the Plan when these mandatory controls were installed; many applauded it as a long over-due step.

Coincident with implementation of this expanded utilization control plan, PHP hired a fulltime medical services director (an experienced RN), whose responsibilities included the overall management of all review activities. A quarterly newsletter was also implemented to advise plan members on such matters as their responsibilities to follow protocols and the need to verify in advance that physicians to whom they might be referred were under contract with PHP.

The reasons that PHP doctors responded so favorably to implementation of mandatory utilization controls can probably be traced to two factors: the real impact of the changes on the practice of PHP doctors and competitive considerations. For the majority of the plan's participating doctors, hospital controls had no practical impact -- little of their practice involved treating patients in the hospital; still less involved PHP members. The two combined left little to be concerned about.

Competition was also a significant factor. To the extent that PHP doctors dropped out of the plan, they faced the prospect of losing their patients to the other HMOs in the area. Compared to this possibility and a growing

writeoff of their fees due to cost overruns in the plan, utilization controls probably did not seem very serious.

- Stage 7: "Mental health and chemical dependency services remain a major problem -- the admission controls are simply not working in this area."

The mandatory pre-admission controls were received with mixed emotions and approximately a dozen doctors dropped out of the plan. Knowledge of disciplinary action taken against some doctors by PHP (through the credentials committee) spread quickly in the medical community, compliance with the new system increased, and PHP's financial statements improved dramatically. One area of hospitalization, however, remained a severe problem: mental health, chemical dependency and alcoholism treatment (required by state law to be at least 73 days per year) still was not under control. Adequate parameters for treatment sources and protocols in this area did not exist, and there were minimal incentives for providers to use the more cost-effective treatment options.

Stage 7

New Elements of Control System

- immediate application of disciplinary action against all non-complying doctors
- development of capitation arrangements with a single clinic for <u>all</u> mental health and chemical dependency care

What followed was a turning point in PHP's history. The Plan entered into a contractual agreement with a local psychiatric clinic, which was thereafter to serve as a "triage" for all mental health and chemical dependency care -- both in- and outpatient. Referrals would be made to the Plan's 50+ participating psychiatrists when the clinic felt that their services were necessary. The agreement provided for payment by PHP of a fixed per capita rate for all mental health and chemical dependency care, thereafter fixing the Plan's liability for this area of health services.

And the controls worked. Mental health/chemical dependency bed days were cut dramatically over an 18-month period:

Year	MH/CD Hospital Bed Days Per 1,000 Members
1977 (pre-controls)	634
1978 (after controls)	532
1979 (11 months experience)	484 (year to date)

In addition, disciplinary procedures were modified to provide for forfeiture of fees in all cases where a physician failed to follow hospital or psychiatric protocols, or referred improperly to a non-participating provider.

- Stage 8: "The office practice of some of our doctors is simply too costly for us."

This realization marked still another basic change in focus for PHP. The Plan could finally say that its hospital controls were working and attention could be turned to other areas.

The focus of the physician office reviews was toward identification of those doctors whose style of practice was simply unaffordable by the Plan. No attempt was made to pass judgment on the appropriateness of individual office visits, laboratory, x-ray or other services. The focus was (and still is) on evaluating cost over a substantial period of time, for many PHP patients.

Sample Format for Outpatient
Medical Reviews

Doctor	# Patients	Frequency Visits	Cost Per Visit	Cost Per Patient
1	61	1.0	$35	$245
2	152	2.0	$31	$ 62
3	106	4.0	$13	$ 52
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
Average for Specialty	97	3.4	$14.90	$ 50.66

As a result of these analyses, approximately 5-8% of the physicians reviewed were disciplined in some manner -- a number were terminated, a few resigned, a number of others elected to remain in the Plan, but the condition of their doing so was that they repay future overages between their average cost per patient and that for their specialty as a whole.

Stage 8

New Elements of Controls

- credential committee review of all physician applications for membership in PHP
- close scrutiny of practice patterns within various medical specialties
- strong disciplinary action taken against those deviating from the "norm" for their specialty
- pharmacy/drug utilization review initiated

The role of the Credentials Committeee in this ambulatory review process was, and probably still is, somewhat unique. Analyses of each medical specialty are prepared by computer, in accordance with the format outlined above. Typically the period of time covered is over a year.

In those instances where diagnosis or other similar reason are not found to explain why a particular doctor varies significantly from his specialty in terms of cost per patient, the matter is referred to the Credentials Committee for action. They review the data, meet personally with the doctor and take some type of formal action in response to what is found. Where no satisfactory explanation is found for a particular doctor varying significantly from his or her peers, three options are presented: resignation, termination, or remaining in the plan but reimbursing it for any future average between the individual doctors average cost per visit and that of his or her specialty as a whole.

Summary of PHP's Current Utilization/Cost Control Systems, Protocols and Procedures

By area of impact, key elements of PHP's utilization/cost control system as it presently exists are as follows:

Hospital Services

- prior approval of all non-emergency admissions and lengths of stay
- disciplinary procedures: failure to follow procedures results in all instances in denial of the doctor's fees
- detailed review of hospital emergency room use -- by physician and by member -- denial of inappropriate claims, disciplinary action against problem physicians
- significant hospital emergency room copayments

Mental Health/Chemical Dependency Care

- fixed per capita cost contract for all mental health/chemical dependency services
- triage system to approve all non-emergency in- and outpatient care in advance
- member copayments

Physician Office Services

- fee ceilings applicable to every medical procedure -- same maximum applicable to all doctors who perform a given procedure
- frequent comparison of physicians in each specialty against their peer doctors from the same specialty: to identify abuse of office services

Outpatient Prescription Drug Services

- fixed per capita cost contract with pharmacists
- frequent pharmacy cost audits
- frequent profiling of prescribing habits of Plan doctors
- profiling of member use to identify Rx abuse
- implementation of Maximum Allowable Cost (MAC) program under which the payment to the pharmacy is based on the lowest cost, generally equivalent prescription available in the area
- limitations on pharmacy markups at the 90th percentile of all participating facilities in the plan

Out-of-Plan Referrals

- all require prior written approval of PHP management
- inappropriate referrals by physicians result in all cases in loss of fees

Group Rating

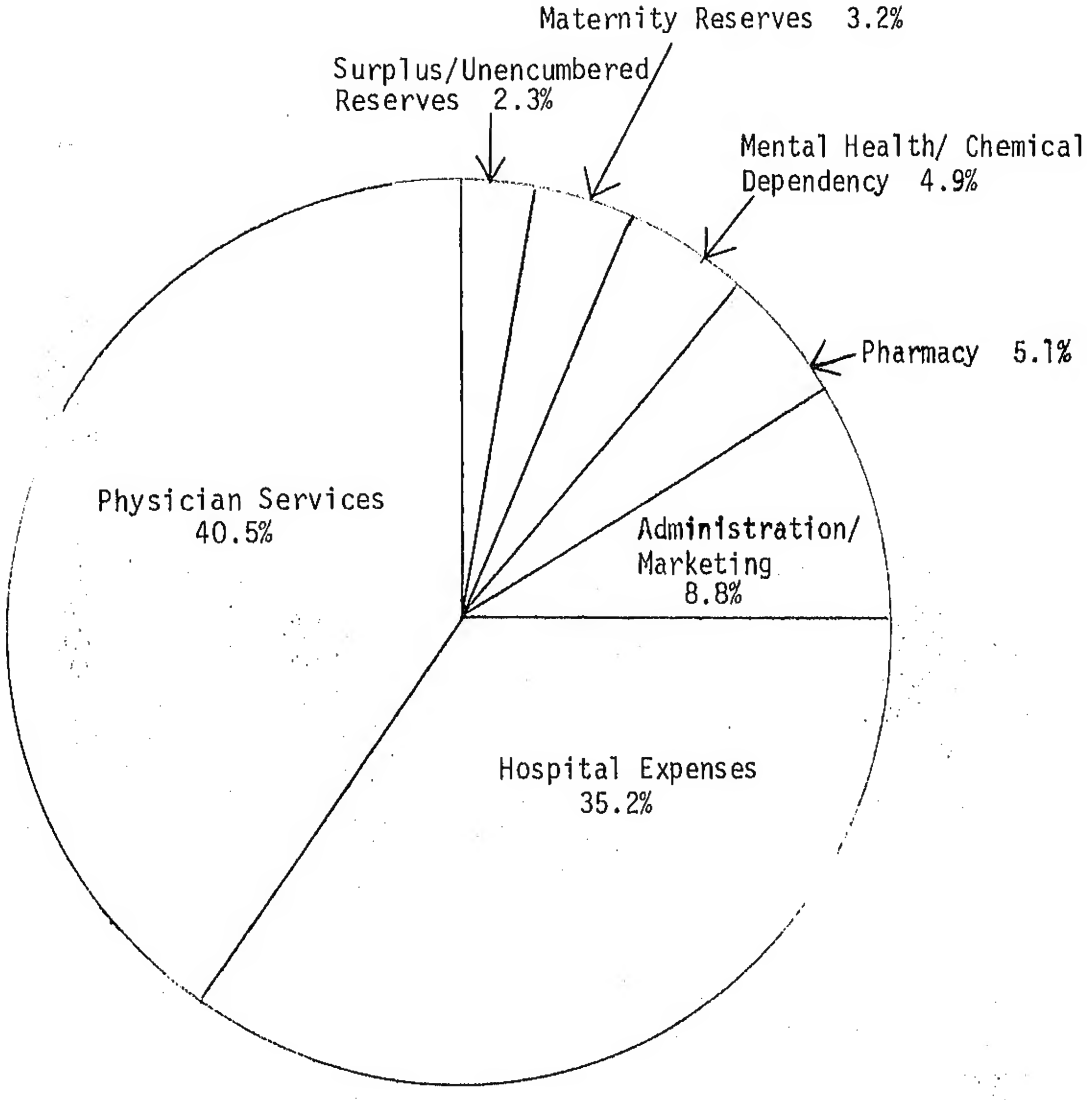
- establishment of initial rates at levels which allow the plan to compete effectively in all groups and enroll a balanced cross-section of health risks
- experience rating all enrolled groups

Marketing/Other

- contract language to allow denial of claims for unauthorized use of non-participating providers, failure to follow mental health/chemical dependency protocols, inappropriate use of hospital emergency room, medical unnecessary services and supplies

- training of marketing staff and preparation of new member material to emphasize member responsibilities in using the system

Allocation of PHP Premium Dollar
1979



Conclusions

The following conclusions are most apparent from the experiences of the Physicians Health Plan:

1. This same scenario has been repeated, in varying forms, in many other IPA-HMOs. It is not unique to PHP because of its size, the nature of the community, the integrity of a few doctors, the sponsors of this particular Plan, local competitive considerations or other such factors. It will occur again where the sponsors of IPAs fail to recognize that mandatory utilization and cost controls are necessary and that change is an essential aspect of the success of such a plan.

2. If an IPA begins operation without a functioning[3] mandatory utilization review system, it all but assures itself financial problems.

3. The dollar incentives inherent in the typical IPA (the amount withheld from physician fees and/or some unspecified liability for adverse hospital experience) are generally not adequate to motivate the necessary changes on the part of plan doctors. The experience of PHP and many other such plans suggests that unless these incentives are accompanied by mandatory controls governing the use of hospital services, they will not work adequately.

4. Development and operation of an effective utilization review program involves at least the following:

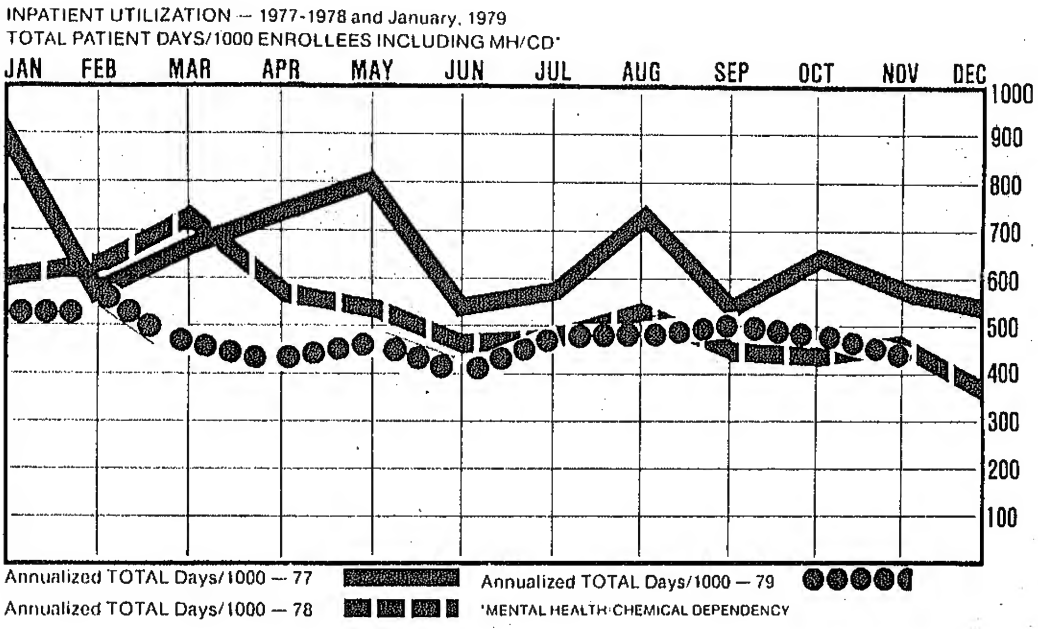
    a. proper design and implementation
    b. hard-nosed administrative (review of individual claims)
    c. effective communication (with individual doctors)
    d. strong disciplinary procedures to deal with those individuals who do not comply with the system

3. "Functioning" in this sense means the design on paper, all committees appointed and operational, "protocols" finalized, printed and distributed.

The first two tasks can be performed by non-medical personnel (unless the Plan elects to hire a fulltime physician to perform the second function). It is both unfair (and generally ineffective) to ask a participating doctor to be objective in evaluating the activities of his peers, particularly if the doctor must work with another physician on a day-to-day basis and/or is dependent upon the doctor for referrals.

5. Utilization/cost controls do work and can do so with no sacrifice in the quality of medical care provided plan members. The following chart highlights PHP's experience in this regard over the past three years.

Inpatient Utilization -- 1977, 1978 and 1979 (partial results)



Complaints from plan members have in fact been less frequent since utilization controls were implemented than before.

Other Comparative Utilization Statistics

Year	Admissions per 1,000 Members	Average Hospital Length of Stay
1977 (9 months without controls)	108.88	5.9
1978 (after controls)	95.5	5.5
1979 (11 months experience)	91.5	4.7

6. An effective utilization/cost control program must encompass more than controls on the Plan's doctors. Included should be the controls themselves, incentives for the patients to use services properly (copayments in certain areas), strong disciplinary mechanisms to deal with non-compliance, tight contract language, frequent communication with members and physicians, marketing/member instructional material which emphasizes contract requirements and patient responsibilities, rating procedures which facilitate enrollment of a reasonably balanced cross-section of health risks and groups. All are important.

As PHP's experience suggests, IPAs can in fact compete effectively, both with commercial insurance/Blue Cross-Blue Shield plans and with other types

PHP's hospital utilization rate is actually below that of a number
closed-panel HMO competitors; its rates are likewise
and the Plan has made money in every month since October 1977
after the mandatory hospital utilization controls were
). January 1, 1981, enrollment is projected at 75,000;
1982, at 98,000. There is no reason that other IPAs cannot
as well, if not better.

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